



George N. Copadis  
Labor Commissioner

David M. Wihby  
Deputy Labor  
Commissioner

## State of New Hampshire Department of Labor

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### REQUEST FOR JOB MODIFICATION PLAN APPROVAL

EMPLOYEE NAME: \_\_\_\_\_ SSN: \_\_\_\_\_ DOI: \_\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_ FEIN: \_\_\_\_\_ TELEPHONE: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_

DESCRIPTION OF EMPLOYEE'S IMPAIRMENT WITH ATTACHED MEDICAL RELEASE TO RETURN TO  
WORK OR WITH ANTICIPATED RELEASE DATE:

DESCRIBE THE SPECIFIC JOB MODIFICATIONS:

PROPOSED COSTS FOR MATERIALS, EQUIPMENT, AND LABOR WITH ESTIMATES:

DATE SUBMITTED: \_\_\_\_\_  
SUBMITTED BY: \_\_\_\_\_  
TITLE \_\_\_\_\_

Send check to:

Attention \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_ APPROVED  
\_\_\_\_ NOT APPROVED

\_\_\_\_\_  
DEPARTMENT REPRESENTATIVE    DATE